Wisconsin Department of Regulation & Licensing

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MEDICAL EXAMINING BOARD

PRACTICE OF RESPIRATORY CARE

LAST NAME: _____ FIRST NAME: _____ MI: _____
(Please Print)

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Enter the percentages of time you have engaged in practice, taught or directed respiratory care in one or more of the categories listed below during the last three years.

NUMBERS 1 – 7 MUST EQUAL 100%

Categories and percentages of practice of respiratory care:	**Percentage**
1. Aerosalize Medication	_____
2. Oxygen Therapy	_____
3. Cardio-Pulmonary Diagnostics (e.g. ABG, PFT, ECG)	_____
4. Non-invasive Cardio-Pulmonary monitoring (e.g. Apnea, Oximetry, Capnography)	_____
5. Bronchial Hygiene Therapy (e.g. CPT, IPPB, Incentive Spirometry)	_____
6. Cardiology, Special Procedures (e.g. Cath Lab, Stress Testing)	_____
7. Ventilator Care/Airway Management	_____
TOTAL	**100%**

Name, address, and telephone number of individual who may be contacted to verify the above:

Name: _____ Date: _____
(Please Print)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

_____
Applicant's Signature

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